Anakinra (Kineret®) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) *OR* the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER	RETAIL
IF the prescription is to be filled through the TRICARE Mail Order Pharmacy, check here ☐	**IF the prescription is to be filled at a retail pharmacy under the TRICARE Retail Pharmacy Program, check here** ☐
• The provider should complete the form, sign, and date • The provider may **fax** the completed form and the prescription to **1-877-895-1900** or 1-602-586-3911 (commercial) **OR** • The patient may attach the completed request form to the prescription and **mail** it to the TMOP at: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**	To request prior authorization, the provider may **call** this number: • **1-866-684-4488** OR • The provider may complete the form, sign, date, and **fax** to **1-866-684-4477**

Prior authorization criteria and a copy of this form are available at: http://www.tricare.osd.mil/pharmacy/prior_auth.cfm. This prior authorization has no expiration date.

Drug for which Prior Authorization is requested: Anakinra (Kineret®)

Step 1

Please complete patient and physician information (Please Print)

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID# _____ Phone #: _____

Secure Fax #: _____

Step 2

Please complete the clinical assessment:

1. **Is this a continuation of therapy with anakinra?**	☐ Yes Coverage approved, limited to a quantity not to exceed 56 syringes (2 packages of 28 syringes) per 8 weeks.	☐ No Please proceed to Question 2
2. **Is the patient at least 18 years of age?**	☐ Yes Please proceed to Question 3	☐ No Coverage not approved
3. **Is anakinra being prescribed for the treatment of moderately to severely active rheumatoid arthritis?**	☐ Yes Please proceed to Question 4	☐ No Coverage not approved
4. **Will the patient be receiving adalimumab (Humira), etanercept (Enbrel®) or infliximab (Remicade®) in combination with anakinra?**	☐ Yes Coverage not approved	☐ No Please proceed to Question 5
5. **Has the patient had an inadequate response to at least one disease-modifying anti-rheumatic drug (DMARD)?**	☐ Yes Coverage approved, limited to a quantity not to exceed 56 syringes (2 packages of 28 syringes) per 8 weeks.	☐ No Coverage not approved

Step 3

I certify the above is correct and accurate to the best of my knowledge.
Please sign and date.

_____ _____

Prescriber Signature Date

Latest revision: July 2005